Virginia Department of Health

Office of Licensure and Certification

Revised October 2006

Facility Internal Investigations of Abuse, Neglect, and Misappropriation of Resident Personnel Property

Principle

Nursing facility residents shall be free from mistreatment, abuse, neglect and misappropriation of resident property.

Introduction

This guideline has been developed to assist facilities in determining when an incident of mistreatment, abuse, neglect, or misappropriation of resident personnel property has occurred[1]. Incidences of mistreatment, abuse, neglect, and misappropriation of resident property are to be reported to the Adult Protective Services Unit of the Va. Department of Social Services as required by § 63.2-1606 of the Code of Virginia. Each year, facility administrators must certify that the facility is in compliance with § 32.1-138 of the Code regarding patient rights as part of the licensure renewal application. In addition, certification regulations for federal reimbursement (the Medicare/ Medicaid programs) require that participating facilities keep residents free from harm and abuse.

The Office of Licensure and Certification (OLC) recommends that each facility review and revise, where appropriate, their policies, protocols and practices to ensure compliance with state law and regulations. For federally certified facilities, a companion guideline has been developed regarding reporting of mistreatment, abuse, neglect, and misappropriation of resident property to the OLC in compliance with federal regulation.

It is expected that facility management will exceed these measures to assure that residents are protected from mistreatment, abuse, neglect, and misappropriation of resident personnel property.

Definitions

"Incident" means occurrences or episodes of staff misconduct and injuries of unknown origin.

"Staff" means any employee, volunteer, or contractor of the facility such as facility administrators, administrative staff, physicians, RNs, LPNs, nurse aides, podiatrists, dentists, vocational therapists, beauticians, housekeepers, dietary, laundry, maintenance staff, and laboratory personnel.

[1] Our thanks to the Bureau of Quality Assurance of the Wisconsin Department of Health and Family Services for sharing their guideline.

"Staff misconduct" means (i) mistreatment or abuse of a resident, (ii) neglect of a resident, or (iii) misappropriation of a resident's property by facility staff.

General Rules

A. A facility is expected to implement written policies and procedures that prohibit staff misconduct towards residents, i.e., mistreatment, neglect, abuse, or misappropriation of resident personal property.

Policies and procedures should include, *but are not limited to*:

- How and to whom staff are to report occurrences, including reporting incidences to the facility administrator;
- How internal investigations will be conducted and completed;
- How staff will be trained on the procedures; and
- How residents will be informed of the procedures.

NOTE: Facilities shall follow the reporting criteria of other agencies, such as APS/DSS or DHP, which may vary from this guideline.

Every facility must ensure that its employees, contractors, volunteers, residents and nonresident personnel are knowledgeable about its staff misconduct reporting procedures and requirement.

B. Immediately upon learning of an incident, the facility must take the necessary steps to protect the resident(s) from subsequent incidences of misconduct or injury, while the matter is pending. A facility can learn of an incident from a:

- Verbal or written statement by a resident;
- Verbal or written statement by someone in a position to have knowledge of the incident through direct or indirect observation;
- Discovering an incident after it occurred;
- Hearing about an incident from others;
- Observing injuries to or behavioral changes in a resident;
- Observing misappropriation of a resident's property; or
- Otherwise becoming aware of an incident.

C. Facilities must conduct an internal investigation and document their findings for all alleged incidences at the facility. A thorough internal investigation should include, *but is not limited to:*

- Collecting physical and documentary evidence;
- Interviews of victims and witnesses;
- Collecting other corroborating/disproving evidence;

- Involvement of other regulatory authorities[2] who can assist; and
- Documentation of each step taken during the internal investigation.

These steps should be taken as part of the facility's attempt to determine what, if anything, happened, and the complete factual circumstances surrounding the alleged incident.

D. A timely and thorough internal investigation is critical to substantiate a finding of misconduct. An investigative report provides:

- A record of the investigator's activities and findings so that nothing is left to memory;
- A permanent official record of the investigator's actions, observations and discoveries;
- A basic reference of the case;
- Information on what has been done concerning the case;
- A basis for deciding further action;
- A method to communicate the findings of the case; and
- Information that can be evaluated to detect and identify patterns of conduct.

H. Internal reports should contain five basic elements:

- Individuals involved, i.e., all persons connected in any way with the incident under investigation such as, residents, complainant, suspected individual, witnesses, any others with first hand knowledge. Individuals should be identified in such a manner that they cannot be confused with any other individual;
- Description of the incident in a precise and accurate manner, including observable facts and statements from witnesses;
- Time and date of the incident;
- Specific location of all persons and things related to the incident, including room numbers, wing/corridor locators, objects in the space, noise, furnishings, clothing of victim; and
- Effect on the resident or resident's reaction

Included below are: "Determining Abuse, Neglect and Misappropriation of Property;" "Other Incident Categories;" and "The Seven Key Components in the Detection and Prevention of Abuse." This information is intended as additional reference that may be helpful in determining whether staff misconduct has occurred. This material is not all-inclusive. It is expected that facilities will follow best practices and good clinical protocols in determining occurrences of staff misconduct.

[2] For example, the Adult Protective Services Unit of the Va. Department of Social Services or the appropriate local law enforcement authority (i.e., police or sheriff's office).

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Determining Abuse, Neglect and Misappropriation

ABUSE means the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, or deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain a resident's physical, mental, and psychosocial well-being, including, but not limited to:

1. An act or repeated acts by staff, including but not limited to restraint, isolation or confinement[3], when contrary to a facility's policies and procedures, not part of a resident's care plan, and intentionally causes harm, does any of the following:

a. Causes, or could reasonably be expected to cause, pain or injury to a resident or the death of a resident and the act does not constitute self-defense;

b. Substantially disregards a resident's rights under § 32.1-138 of the *Code of Virginia*, or the facility's duties and obligations to a resident;

c. Causes, or could reasonably be expected to cause, mental or emotional damage to a resident, including harm to the resident's psychological and intellectual functioning exhibited by: anxiety, depression, withdrawal, regression, outward aggressive behavior, agitation, or fear of harm or death, or a combination of these behaviors.

2. An act or acts of sexual intercourse or sexual contact by staff and involving a resident;

3. The forcible administration of medication or the performance of psychosurgery, electroconvulsive therapy or experimental research on a resident with the knowledge that no lawful authority exists for the administration or performance;

4. A course of conduct, or repeated acts by staff, which serve no legitimate purpose and which, when done with intent to harass, intimidate, humiliate, threaten or frighten a resident causes, or could reasonably be expected to cause, the resident to feel harassed, intimated, humiliated, threatened, or frightened.

Examples include: physical abuse, verbal abuse, sexual abuse, and mental abuse.

- Physical Abuse

  – Hitting, slapping, pinching, kicking, shoving, pushing, non-therapeutic pulling or twisting any part of the resident's body, burning, sticking a resident with an object, or striking a resident with a part of the body or with an object

  - Physical contact intentionally or through carelessness that results in, or is likely to result in, death, physical injury, pain or psychological harm to the resident. Indications of psychological harm include a noticeable level of fear, anxiety, agitation or emotional distress in the resident

  - Use of any restraints, involuntary seclusion, or isolation of a resident as a method of punishing a resident

  - Use of any restraints in an unreasonable manner, such as tying the hands or legs together

[3] This does not apply to restraint, isolation or confinement permissible by law or regulation.

- Use of physical restraints for prolonged periods of time
- Acts of physical retaliation, even in response to a physical attack

NOTE: Accidental injury due to self-defense or to prevent injury to another resident would not normally be considered abuse. An example would be a skin tear occurring when a staff member grabbed a resident's wrist to prevent the resident from striking the staff member or another resident.

- Verbal abuse
  – Threats of harm, saying things to intentionally frighten a resident, statements that result in ridicule or humiliation
  - Any use of oral, written or gestured language that includes cursing, disparaging and derogatory terms to other residents or visitors within hearing range, to describe a resident, regardless of their age, ability to comprehend, or disability

- Sexual abuse
  – Harassment, inappropriate touching, assault, and sexual coercion
  - Allowing a resident to be sexually abused by another

- Mental abuse
  – Humiliation, harassment, and intimidation with threats of punishment or threats of depriving care or possessions, malicious teasing[4]
  - Not giving reasonable consideration to a resident's wishes, unreasonably restricting contact with family, friends or other residents, ignoring resident needs for verbal and emotional contact.
  - Violation of a resident's right to confidentiality by discussing a resident's condition, treatment of personal affairs with anyone who does not have a right to such information.

Neglect means a failure to provide timely and consistent services, treatment or care to a resident or residents which are necessary to obtain or maintain the resident's health, safety or comfort; or a failure to provide timely and consistent goods and services necessary to avoid physical harm, mental anguish, or mental illness, including but not limited to, acts that:

1. Cause, or could reasonable be expected to cause, pain or injury to a resident or the death of a resident;
2. Substantially disregards a resident's rights under § 32.1-138 of the Code of Virginia, or the facility's duties and obligations to a resident;
3. Cause or could reasonably be expected to cause, mental or emotional damage to a resident, including harm to the resident's psychological or intellectual functioning that is exhibited by anxiety, depression, withdrawal, regression, outward aggressive behavior, agitation, fear of harm or death, or a combination of these behaviors.

[4] Non-malicious teasing does not constitute abuse unless it causes the resident to feel degraded.

Neglect is the intentional carelessness, negligence, or disregard of policy, or care, that causes, or could reasonably be expected to cause, pain, injury, or death. The major difference between abuse and neglect is that in a case of abuse, harm was intended; in neglect, the staff person did not intend to harm the resident.

Examples of neglect include, but are not limited to:

- Failure to provide adequate nutrition and fluids
- Failure to take precautionary measures to protect the health and safety of the resident
- Intentional lack of attention to physical needs including, but not limited to, toileting and bathing
- Failure to provide services that result in harm to the resident, such as not turning a bedfast resident or leaving a resident in a soiled bed
- Failure or refusal to provide a service for the purpose of punishing or disciplining a resident, unless withholding of a service is being used as part of a documented integrated behavioral management program
- Failure to notify a resident's legal representative in the event of a significant change in the resident's physical, mental or emotional condition that a prudent person would recognize
- Failure to notify a resident's legal representative in the event of an occurrence involving the resident, such as failure to report a fall or a conflict between residents that result in injury or possible injury
- Failure to report observed or suspected abuse, neglect or misappropriation of resident property to the proper authorities
- Failure to adequately supervise a resident known to wander from the facility without staff knowledge

NOTE: Such things as failure to comb a resident's hair on occasion would not necessarily constitute a reportable incidence of neglect. However, continued omission in providing personal grooming and/or failure to address and resolve the omission could constitute neglect.

Misappropriation of Personal Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent, including but not limited to:

1. The intentional taking, carrying away, using, transferring, concealing or retaining possession of a resident's movable property without the resident's consent and with the intent to deprive the resident of possession of the property.
2. Obtaining property of a resident by intentionally deceiving a resident with a false representation[5] which is known to be false, made with the intent to defraud, and which does

[5] False representation means a promise made with the intent not to perform if if the promise is a part of a false or fraudulent scheme.

defraud the person to whom it is made

3. By virtue of his or her office, business or employment, or as a trustee or bailee, having possession or custody of money or of a negotiable security, instrument, paper or other negotiable writing of a resident, intentionally using, transferring, concealing, or retaining possession of money, security, instrument, paper or writing without the resident's consent, contrary to his or her authority, and with the intent to convert it to his or her own use or the use of another person or persons except the resident.

4. Intentionally using or attempting to use a resident's personal identifying information, or a resident's birth certificate or financial transaction card, to obtain credit, money, goods, services or anything else of value without the authorization or consent of the resident and by representing that he or she is the resident or is acting with the authorization or consent of the resident. Examples of misappropriation include:

- Theft, or attempted theft, of a resident's medication, money, credit cards, jewelry, or personal property
- Inappropriate use of resident funds or property.
- Use of a resident's telephone without their expressed permission.

Other Incident Categories

Injuries of Unknown Origin

Injuries of unknown origin should be handled the same as an occurrence of mistreatment, neglect or abuse and must be reported to the OLC if there is *reasonable cause to believe* that an injury has been inflicted upon a resident by facility staff.[6] If there is no reasonable cause to believe that an injury has been inflicted upon a resident or that the resident has been neglected, then the facility does not have to report the occurrence. The facility must establish a protocol or procedure for determining whether injuries such as skin tears, bruises, abrasions and other events occurring in the facility are abusive or neglectful or whether these occurrences are unavoidable.

NOTE: The facility is not relieved of its responsibility to investigate the occurrence, regardless of the circumstances, and complete a report. Facility documentation should support the decision not to report a specific occurrence or accident to the OLC. If, in the course of an investigation, the facility determines that the occurrence is reportable, the facility is expected to file a report with the OLC.

[6] Facilities shall follow the reporting criteria of other agencies, such as APS/DSS or DHP, which may vary from this guideline.

Resident to Resident

Resident to resident altercations do not have to be reported[7] *if the facility takes immediate and appropriate actions* to intervene in the situation and provides sufficient supervision and monitoring to limit the probability of recurrence. Residents who are abusive to other residents must be monitored and must have a care plan that addresses the abusive behavior. Those who are victims of abuse must be protected from further injury or mental anguish.

NOTE: Resident to resident altercations in which a resident is injured and requires physician intervention and/or transfer or discharge to a hospital *must* be reported to the OLC.

Facility Visitor to Resident Abuse

Individuals visiting the facility and who mistreat or who are abusive to residents must be monitored and the resident or residents *must* be protected to assure that further abuse or mistreatment does not occur. In all cases of visitor to resident abuse, mistreatment, or misappropriation of property, the appropriate law enforcement agency *must be* notified.

Unusual Occurrences

The OLC recommends facilities include unusual incidents or occurrences to their reporting criteria and report any such occurrences immediately. Examples of unusual occurrences include:

- Any event involving a resident that is likely to result in legal action;
- Medication errors that result in the resident being hospitalized or dying;
- Suicides - attempted or successful;
- Death or serious injury associated with the use of restraints;
- Ingestion of toxic substances requiring medical intervention;
- Accidents or injuries of known origin that are unusual, such as a resident falling out of a window, a resident exiting the facility and sustaining an injury on facility property, or a resident being burned;
- A resident procuring and ingesting enough medication to result in an overdose; and
- Any unusual event involving a resident or residents that may result in media coverage.

[7] Facilities shall follow the reporting criteria of other agencies, such as APS/DSS or DHP, which may vary from this guideline.

The Seven Key Components in the Detection and Prevention of Abuse[8]

1. Prevent - The provider has the capacity to detect and prevent the occurrence of abuse and neglect, and reviews specific incidents for "lessons learned," which form a feedback loop to affect necessary policy changes.

2. Screen - The provider makes the effort to determine the appropriateness of a prospective employee's experience in working with individuals with specific conditions and needs, and seeks to identify and verify any previous charges of abuse and neglect of a prospective employee. The provider also screens individuals receiving services to determine whether the individual's needs can be appropriately addressed within the provider's setting.

3. Identify - The provider creates and maintains a proactive approach for identifying events and occurrences that may constitute or contribute to abuse and neglect.

4. Train - The provider gives all employees – through orientation and *ongoing* training programs – information regarding abuse and neglect. Training should include reporting requirements and procedures for protection, intervention, and prevention. Individuals receiving services should be trained to recognize and identify signs and symptoms of abuse and neglect; they should also be informed of ways in which they and their family members can support detection and prevention efforts.

5. Protect - The provider seeks generally to support and protect individuals receiving services, their families, and staff. Additionally, the provider makes an effort to protect individuals from abuse and neglect during investigations of allegations of abuse and neglect.

6. Report and Investigate - The provider puts in place measures that facilitate and assure the reporting of abuse and neglect. The provider also assures a timely, thorough, and objective investigation of all allegations of abuse, neglect, or mistreatment.

7. Respond - The providers assures that the appropriate corrective, remedial, or disciplinary action occurs in accordance with applicable local, state, or federal law, in response to findings resulting from investigations.

[8] Extracted from CMS's "Abuse and Neglect Detection and Prevention – Participant Guide."